

Portal “How To” 101

Indiana Health Coverage Programs
DXC Technology
IHCP Works Seminar October 2020



Agenda

- Verify member eligibility
- Eligibility – special programs
- Provider enrollment
- IHCP Portal overview
- Member focused viewing
- Prior authorization – fee-for service (FFS)
- Claims – FFS
- Search payment history
- Reminders
- Helpful tools
- Questions



Verify Member Eligibility



Verify Eligibility

Verification options



- Interactive Voice Response (IVR) system at 1-800-457-4584
- IHCP Provider Healthcare Portal (Portal) at <https://portal.indianamedicaid.com>
- Electronic 270/271 interactive or batch transactions

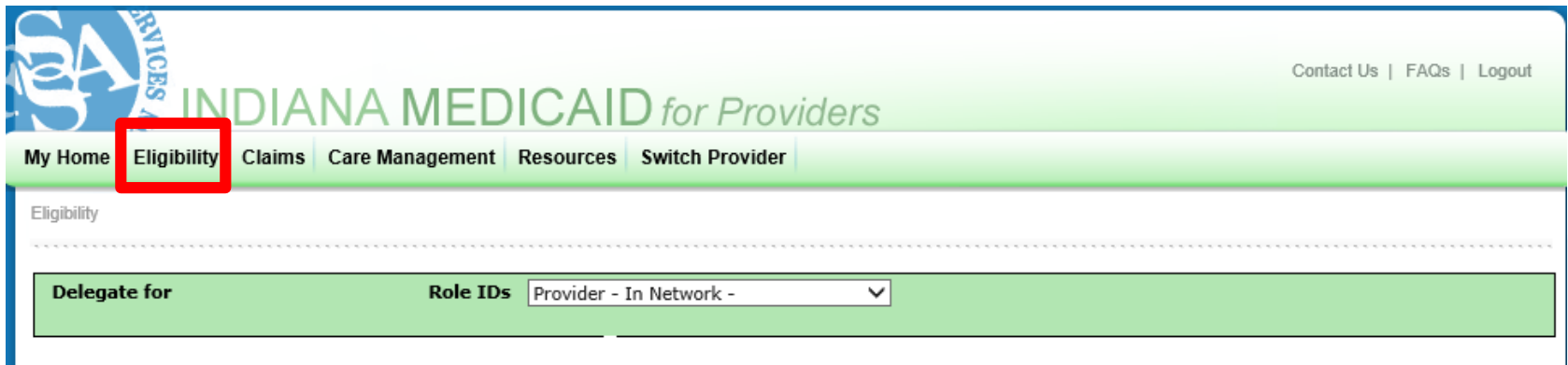
Verify eligibility on every visit!



Verify Eligibility on Portal

- Eligibility can only be verified as of provider effective date
- Eligibility cannot be verified for future dates

To access the *Eligibility Verification Request* function, log in to the Provider Healthcare Portal and click **Eligibility** on the menu bar.



INDIANA MEDICAID for Providers

Contact Us | FAQs | Logout

My Home **Eligibility** Claims Care Management Resources Switch Provider

Eligibility

Delegate for Role IDs Provider - In Network -

IMPORTANT!!!!

Eligibility is determined by the Division of Family Resources (DFR). DXC cannot change eligibility demographics.



Verify Member Eligibility



To perform a search, the *Effective From* date is required, in addition to one of the following:

- Member ID
- Social Security number (SSN) and birth date
- Last name, first name, and birth date

Eligibility Verification Request ?

* Indicates a required field.

Enter the member information. If Member ID is not known, enter SSN and Birth Date, or Last Name, First Name, and Birth Date.

Member ID	<input type="text"/>	Last Name	<input type="text"/>	First Name	<input type="text"/>
SSN	<input type="text"/>	Birth Date	<input type="text"/>		
*Effective From	<input type="text" value="09/08/2020"/>	Effective To	<input type="text"/>		

Verify Member Eligibility

The **Effective From** field is always required.

- If a date is not entered, the Portal defaults this field to the current date.
- This field accepts only current and previous dates.

The **Effective To** field is optional.

- The date entered must be on or after the Effective From date and must be **within the same calendar month** as the Effective From date.
- If a date is not entered, the Portal defaults to the Effective From date.

The screenshot shows a web form titled "Eligibility Verification Request". At the top, a blue banner contains the title. Below the banner, a legend indicates that an asterisk (*) denotes a required field. The form instructions state: "Enter the member information. If Member ID is not known, enter SSN and Birth Date, or Last Name, First Name, and Birth Date." The form fields are arranged in two columns. The left column contains "Member ID", "SSN", and "Effective From". The right column contains "Last Name", "Birth Date", and "Effective To". "First Name" is a separate field to the right of "Last Name". Red arrows point from the text boxes above to the "Effective From" and "Effective To" fields. At the bottom of the form are "Submit" and "Reset" buttons.

Member ID		Last Name		First Name	
SSN		Birth Date			
*Effective From		Effective To			

Submit Reset



Verify Member Eligibility

No Results Found:

Error

Member not found, confirm and/or revise search criteria.



Eligibility Verification Request ?

* Indicates a required field.
Enter the member information. If Member ID is not known, enter SSN and Birth Date, or Last Name, First Name, and Birth Date.

Member ID	<input type="text"/>	Last Name	<input type="text"/>	First Name	<input type="text"/>
SSN*	<input type="text"/>	Birth Date*	<input type="text"/>		
Effective From	<input type="text"/>	Effective To*	<input type="text"/>		

When an eligibility search returns no results, qualified providers (QPs) see an additional option below the message to complete a Presumptive Eligibility for Pregnant Women (PEPW) or Presumptive Eligibility (PE) application for the patient.


What is Presumptive Eligibility?

Presumptive Eligibility (PE) is an Indiana Health Coverage Programs (IHCP) process by which individuals are deemed to be presumptively eligible for **temporary** coverage, until the Family and Social Services Administration (FSSA) determines official eligibility.



Verify Member Eligibility

Some members may have more than one coverage type listed. Each benefit plan plays an important role, depending on provider type.

Benefit Details 			
Coverage	Description	Effective Date	End Date
Full Medicaid	Full Medicaid for individuals who are 65 years old, blind, or disabled (FFS or Managed Care)	07/16/2019	07/16/2019
Medicaid Rehabilitation Option	Medicaid Rehabilitation Option for Adults with Level of Need = 3, Service Package 3	07/16/2019	07/16/2019
Qualified Medicare Beneficiary	Qualified Medicare Beneficiary - Members for whom co-insurance and deductibles are paid as well as Medicare Part B premiums	07/16/2019	07/16/2019
Family Supports HCBS Waiver	Authorized Family Supports HCBS Waiver services found in the Notice of Action (NOA)	07/16/2019	07/16/2019

Eligibility – Managed Care

Limit Details



Managed Care Assignment Details



Demographic Details



Managed Care Assignment Details



Managed Care Program		Primary Medical Provider	Provider Phone
Hoosier Care Connect			
Effective Date	End Date	MCO / CMO Name	MCO / CMO Phone
08/02/2019	08/02/2019	ANTHEM	1-844-284-1797

Eligibility – Fee-for-Service (FFS)

Southeastrans is the managed care entity for nonemergency medical transportation (NEMT) for fee-for-service (FFS) members.

Benefit Details

Coverage	Description	Effective Date	End Date
Full Medicaid	Full Medicaid for individuals who are 65 years old, blind, or disabled (FFS or Managed Care)	08/02/2019	08/02/2019

Managed Care Assignment Details

Managed Care Program		Primary Medical Provider	Provider Phone
Fee for Service + NEMT			
Effective Date	End Date	MCO / CMO Name	MCO / CMO Phone
08/02/2019	08/02/2019	SOUTHEASTRANS, INC	

What is the Right Choices Program?

Members identified with high utilization are assigned to primary lock-in providers, such as:

- One primary medical provider (PCP)
- One pharmacy
- Approved specialty providers



Bulletin *BT202024*

- Primary lock-in hospital will no longer be required
- Existing hospital lock-in assignments listed on the member's Right Choices Program (RCP) lock-in list ended effective April 30, 2020

Members should be referred to their lock-in provider.



How Do I Know Who the Lock-in Providers Are?

Managed Care Assignment Details



Right Choices Program



Demographic Details



Right Choices Program

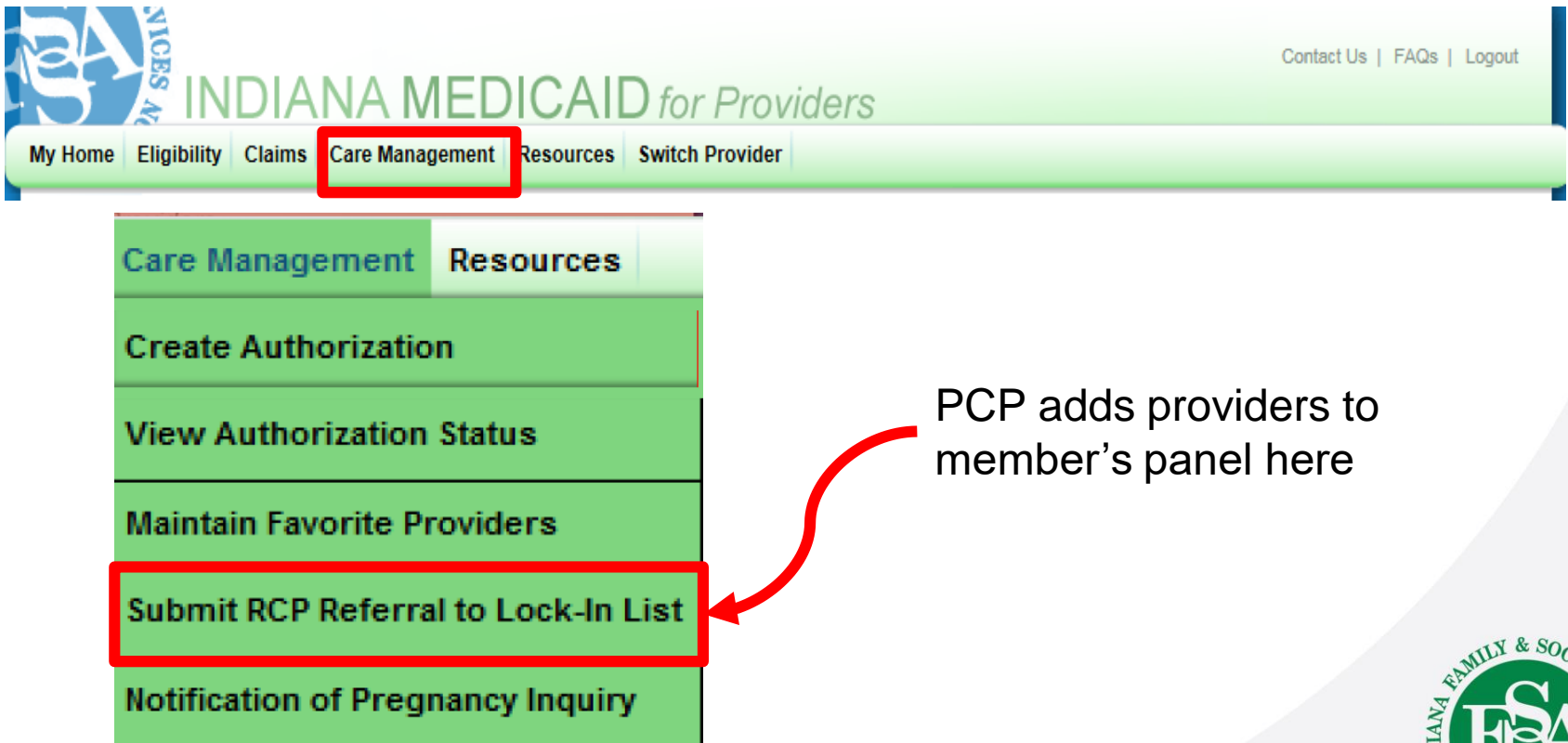


✓ Indicates a PMP Provider.

RCP Provider	PMP	RCP Provider Phone	Service	Effective Date	End Date
XXXXXXXXXX	Yes ✓	XXXXXXXXXX	RCP-Physician	07/29/2019	07/29/2019
XXXXXXXXXX	No	XXXXXXXXXX	RCP-Pharmacy	07/29/2019	07/29/2019

Right Choices Program

Contact the Right Choices Program member's primary care physician (PCP) to be added to member's panel.



The screenshot displays the 'INDIANA MEDICAID for Providers' web portal. The top navigation bar includes links for 'Contact Us', 'FAQs', and 'Logout'. Below this, a secondary navigation bar contains 'My Home', 'Eligibility', 'Claims', 'Care Management', 'Resources', and 'Switch Provider'. The 'Care Management' link is highlighted with a red box. A dropdown menu is open under 'Care Management', listing several options: 'Create Authorization', 'View Authorization Status', 'Maintain Favorite Providers', 'Submit RCP Referral to Lock-In List', and 'Notification of Pregnancy Inquiry'. The 'Submit RCP Referral to Lock-In List' option is highlighted with a red box. A red arrow points from the text 'PCP adds providers to member's panel here' to this specific option.

INDIANA MEDICAID for Providers

Contact Us | FAQs | Logout

My Home | Eligibility | Claims | **Care Management** | Resources | Switch Provider

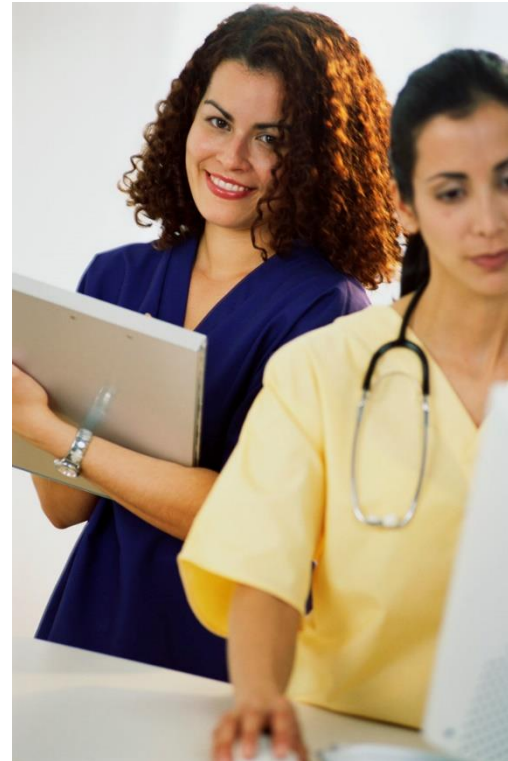
Care Management | Resources

- Create Authorization
- View Authorization Status
- Maintain Favorite Providers
- Submit RCP Referral to Lock-In List**
- Notification of Pregnancy Inquiry

PCP adds providers to member's panel here

Retroactive Eligibility and Claim Billing

- 180 days to bill claims from the date the member becomes retroactive eligible
 - Add claim note: “Retroactive member Eligibility, please waive timely filing”
- Payments made by retroactively approved members should be refunded to the member and claims billed to the payer
- Member is responsible for notifying providers of retroactive eligibility



Timely Filing Reminder!

REMEMBER

- Timely filing is 180 days from the “from” date of service
- Claim corrections should be done via the Portal, however:
 - Do NOT adjust claims on the Portal if the “from” date of service is more than 180 days from the current date
- If there is proof of timely filing following the guidelines and exceptions listed in the *Claim Submission and Processing* module online:
 - Proof MUST be attached to the claim
 - Note MUST be entered explaining why the waiver of timely filing is being requested
 - All dates on documentation attached that validate the timely filing MUST be circled and noted “waive timely filing”



Eligibility – Special Programs




Eligibility – Special Programs

The following are Medicare premium benefits only, and do not require a waiver to bill member:

- **Specified Low-Income Medicare Beneficiary (SLMB)** –
Medicare Part B premiums only
- **Qualified Individual (QI)** –
Medicare Part B premiums only
- **Qualified Disabled Working Individual (QDWI)** –
Medicare Part A premiums only

These members do not have any Medicaid benefits.

Eligibility – Preadmission Screening Resident Review (PASRR)

Benefit Details 			
Coverage	Description	Effective Date	End Date
PASRR Mental Illness (MI)	Pre-Admission Screening and Resident Review (PASRR) Mental Illness claims processing for community mental health centers (CMHC) and diagnostic and evaluation (D&E) teams.	07/16/2019	07/16/2019

- PASRR for nursing homes are the only payable codes
- No other benefits when PASRR is the **only** coverage
- Waiver not required to bill a member for a noncovered service
- Provider must be a PASRR enrolled provider

Eligibility – Medical Review Team (MRT)

- Disability-determining codes only, per the Medicare Review Team Codes
- Provider must be an MRT provider
- No other benefits when MRT is the only coverage
- No waiver form required when MRT is the only coverage

Benefit Details			
Coverage	Description	Effective Date	End Date
Medical Review Team	Medical Review Team procedure codes only	08/02/2019	08/02/2019

Eligibility – 590 Program

- 590 Program members reside in a State institution
- Full array of benefits, except transportation
- Claims for \$150 or less – billed to institution
- \$150 or more – billed to the IHCP
- \$500 or more – requires prior authorization
- Provider must be enrolled in 590 program

Benefit Details			
Coverage	Description	Effective Date	End Date
590 Program	590 Program - Residents in State Mental Health Facilities	08/02/2019	08/02/2019
PASRR Mental Illness (MI)	Pre-Admission Screening and Resident Review (PASRR) Mental Illness claims processing for community mental health centers (CMHC) and diagnostic and evaluation (D&E) teams.	08/02/2019	08/02/2019

Qualified Medicare Beneficiary

What's the difference?

QMB **ALSO**

The IHCP pays member's Medicare, Part B premium and ALSO the member has full Medicaid benefits



Coverage
Full Medicaid
Qualified Medicare Beneficiary
Medicaid Rehabilitation Option
Other Insurance Detail Information

QMB **ONLY**

The IHCP pays the member's Medicare Part B premiums and coinsurance and deductible ONLY. If Medicare does not allow the charge, the IHCP does not allow the charge.



Coverage
Qualified Medicare Beneficiary
Other Insurance Detail Information

Waiver Required!

Waivers

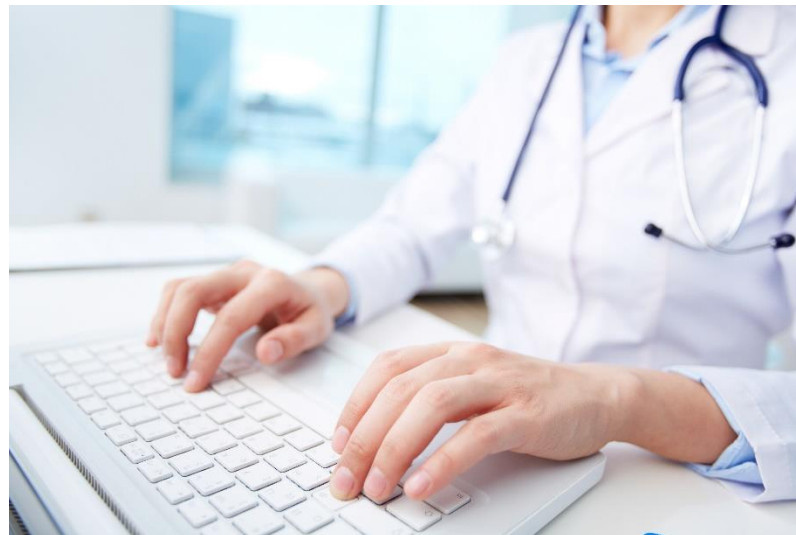
Can I Use the Medicare Advanced Beneficiary Notice (ABN) as My Waiver Form? (for Charging Members)

- No, the ABN cannot be used as a waiver form for charging members
- The waiver should state specifically what services are not covered and why, and explain that the member will be financially liable
 - *The waiver must not include **conditional language** such as “if the service is not covered by the IHCP, or not authorized by the member’s PMP, the member is responsible for payment.”*
- Providers should compose *their own waiver* to provide advance notice to a member that a service is noncovered
- The waiver is to protect the provider, as it provides documentation that the member was informed in advance of noncoverage and financial liability

Retroactive Eligibility

Can the Portal Eligibility Function Show the Date Retroactive Eligibility was Granted? And the Start and End Date of Eligibility?

- Providers should be checking eligibility only for the dates of service (DOS) in question
- Providers should ask the member for a copy of the Medicaid approval letter in retroactive eligibility situations
- Use the *Claim Notes* feature to indicate retroactive eligibility dates, in timely filing limit situations



Provider Enrollment



How Can I Update My Provider Information on File?



User Details

Welcome

- ▶ [My Profile](#)
- ▶ [Manage Accounts](#)



Provider

Name SERVICE LOCATION
NAME

Provider ID

- ▶ [Disenroll](#)
- ▶ [Provider Profile](#)
- ▶ [Provider Maintenance](#)
- ▶ [Enrollment / Revalidation Status](#)

WELCOME HEALTH CARE PROFESSIONAL



We are committed to make it easier for physicians and other providers to perform their business. In addition to providing the ability to verify member eligibility and submit claims, our secure site provides access to benefits, answers to frequently asked questions, and the ability to search for providers.

Provider Enrollment

Login ?

***User ID**

Log In

[Forgot User ID?](#)

[Register Now](#)

[Where do I enter my password?](#)

Protect Your Privacy!

Always log off and close all of your browser windows

Would you like to enroll as a Provider?

[Provider Enrollment](#)

Drug Resources

[Fee-for-Service Pharmacy Resources](#)

- Provider enrollment transactions can be done on the Portal
 - New enrollments
 - Revalidation
 - Profile updates



Provider Enrollment

How do I know when my revalidation is due?

- ▶ [Disenroll](#)
- ▶ [Provider Profile](#)
- ▶ [Provider Maintenance](#)
- ▶ [Enrollment / Revalidation Status](#)



[Revalidation](#)

Revalidation warnings post 90 days before the revalidation is due. Failure to complete revalidation can result in enrollment termination.

Provider Enrollment

What is the Correct Way to Submit a W-9 Form with a Provider Enrollment Application, Update, or Revalidation?

- **#1 reason enrollment applications and updates are denied!!**
- Make sure you use the latest version of the W-9 form from the [irs.gov](https://www.irs.gov) website

Form W-9 (Rev. October 2018) Department of the Treasury Internal Revenue Service		Request for Taxpayer Identification Number and Certification ► Go to www.irs.gov/FormW9 for instructions and the latest information.		Give Form to the requester. Do not send to the IRS.
Print or type. See Specific Instructions on page 3.	1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.			
	2 Business name/disregarded entity name, if different from above			
	3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only one of the following seven boxes.			4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):
	<input type="checkbox"/> Individual/sole proprietor or single-member LLC			Exempt payee code (if any) _____
	<input type="checkbox"/> C Corporation			Exemption from FATCA reporting code (if any) _____
<input type="checkbox"/> S Corporation				
<input type="checkbox"/> Partnership				
<input type="checkbox"/> Trust/estate				
<input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____				
<input type="checkbox"/> Other (see instructions) ► _____				
5 Address (number, street, and apt. or suite no.) See instructions.			Requester's name and address (optional)	
6 City, state, and ZIP code				

IHCP Portal Overview



Portal Home Page

WELCOME HEALTH CARE PROFESSIONAL!



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 [Contact Us](#)

DXC contact information
(phone, fax, mail)

 [Notify Me](#)

Sign up to receive important emails

 [Secure Correspondence](#)

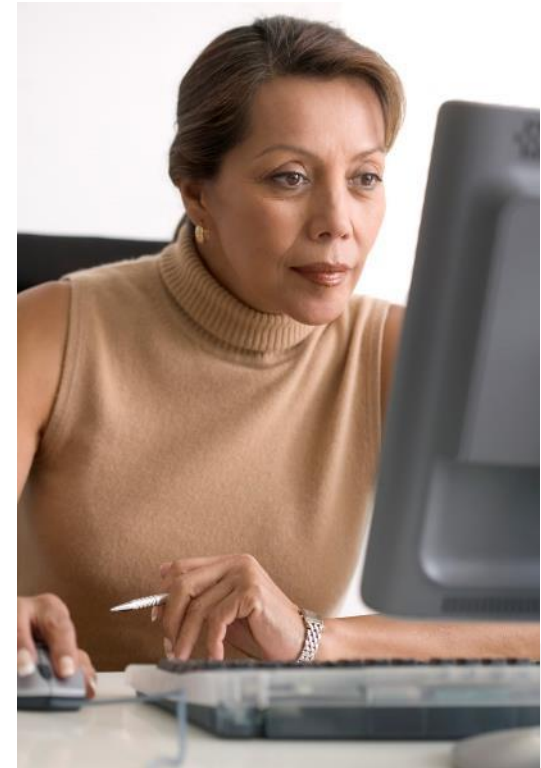
- Claim administrative review requests
- Submit third-party liability (TPL) updates
- Portal assistance

Ask your administrator to give you full access to these features.



Where do I Find Information?

- The resources of the Provider Healthcare Portal will take you to locations for research on the IHCP website at in.gov/medicaid/providers
- Modules, bulletins, banner pages, and special pages dedicated to provider education



Portal Resources



Resources

- ▶ [Claims/Billing](#)
- ▶ [Electronic Data Interchange](#)
- ▶ [Fee Schedule](#)
- ▶ [Forms](#)
- ▶ [Provider Reference Materials](#)
- ▶ [Pharmacy Services](#)
- ▶ [Provider Search](#)
- ▶ [Provider Education](#)
- ▶ [Email Notifications](#)

- Claim adjustment forms
- TPL forms
- Provider correspondence forms

Quick access to the IHCP Fee Schedules

- Workshop registration
- Presentations
- Webinar training



Multiple Locations

- I work for a provider with multiple locations and legacy provider identifiers IHCP Provider IDs. How do I best work within the Portal?
 - Ensure your Delegate access has been added to all locations/LPIs you work under
 - One click Switch Provider option



Switch Providers

My Home Eligibility Claims Care Management Resources **Switch Provider**

My Home

Delegate for Role IDs Provider - In Network -

Member in Focus: Change ID: Return to Me

User Details

Welcome

▶ My Profile

▶ **Switch Provider**

Provider

Name

Provider ID

▶ Disenroll

▶ Provider Profile

▶ Provider Maintenance

▶ Enrollment / Revalidation Status

WELCOME HEALTH CARE PROFESSIONAL



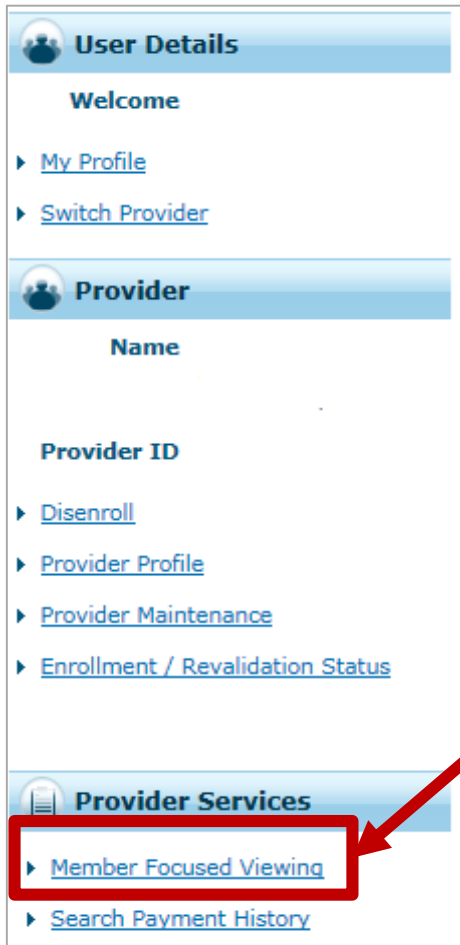
We are committed to make it easier for physicians and other providers to perform their business. In addition to providing the ability to verify member eligibility and submit claims, our secure site provides access to benefits, answers to frequently asked questions, and the ability to search for providers.



Member Focused Viewing

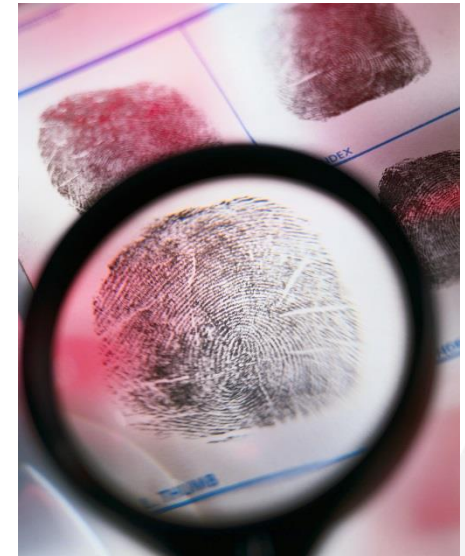


Member Focused Viewing



Member focused viewing allows quick access to:

- Member details
- Coverage details
- Claim search and submission
- Prior authorization search and submission



▶ [Member Focused Viewing](#)

Member Focused Viewing


Same search criteria as the *Eligibility* screen

Member Focus Search

Last Members Viewed Search

* Indicates a required field.

Enter the Member ID or Last Name, First Name and Birth Date. ←

Member ID	<input type="text"/>		
Last Name	<input type="text"/>	First Name	<input type="text"/>
		Birth Date	<input type="text"/> 
City	<input type="text"/>	ZIP Code	<input type="text"/>





Member Details

Member ID
Name
Birth Date
City
State Indiana
Gender Male
Primary Language ENGLISH

Coverage Details

To see details about the member's eligibility information, click **View eligibility verification information**.

Coverage	Effective Date	End Date
Package A-Standard Plan		
Medicaid Rehabilitation Option		

▶ [View eligibility verification information](#)

Other Details



[Secure Correspondence](#)

Review previously sent messages or send new secure messages.

Your Member Claims

Medical/Dental/Institutional

To start entry of a new claim, click the Submit link for the appropriate claim type.
To see details about a specific claim, click the Claim ID.

- ▶ [Submit a Professional Claim](#)
- ▶ [Submit an Institutional Claim](#)

▶ [Submit a Dental Claim](#)

There are no claims for this member.

Your Member Authorizations

To start entry of a new authorization, click **Submit an Authorization**.
To see details about a specific authorization, click the Authorization #.

- ▶ [Submit an Authorization](#)

There are no authorizations for this member.

Prior Authorization Fee-for-Service



Prior Authorization (PA)

Where do I find prior authorization? I've looked everywhere!



The screenshot displays the FSA website interface. At the top, a navigation bar includes links for 'My Home', 'Eligibility', 'Claims', 'Care Management' (highlighted with a red box), 'Resources', and 'Switch Provider'. Below this, a 'Delegate for' section shows a dropdown menu set to 'Provider - In Network -'. A secondary navigation bar on the left lists 'Care Management' and 'Resources'. Under 'Care Management', a dropdown menu is open, showing options: 'Create Authorization' (highlighted with a red box and a red arrow pointing to it), 'View Authorization Status', 'Maintain Favorite Providers', 'Submit RCP Referral to Lock-In List', and 'Notification of Pregnancy Inquiry'. Below the dropdown, there are links for 'Provider Profile', 'Provider Maintenance', and 'Enrollment / Revalidation Status'. The main content area features a 'WELCOME HEALTH CARE PROFESSIONAL' banner with an image of two healthcare professionals. Below the banner, a paragraph states: 'We are committed to make it easier for physicians and other providers to perform their business. In addition to providing the ability to verify member eligibility and submit claims, our secure site provides access to benefits, answers to frequently asked questions, and the ability to search for providers.'

Prior Authorization (PA)

Confirm Authorization

Review all information for the Authorization displayed below. If the information is correct, click the Confirm button. If you want to make any corrections to the Authorization, click the Back button. If you do not want to submit the Authorization request, click the Cancel button.

[Expand All](#) | [Collapse All](#)

Requesting Provider Information

Provider ID	ID Type	NPI	Taxonomy	Name	Rendering Provider
-------------	---------	-----	----------	------	--------------------

Member Information

Member ID	Member	Birth Date	Gender	Female
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Rendering Provider Information

Provider ID	ID Type	NPI	Taxonomy	Name	Rendering Provider
Service Type	DURABLE MEDICAL EQUIPMENT PURCHASE				

[Expand All](#) | [Collapse All](#)

Diagnosis Information

Diagnosis Type	Diagnosis Code
ICD-10-CM	G114-Hereditary spastic paraplegia

Service Details

	From Date	To Date	Code	Modifiers	Units	Dollars
<input type="checkbox"/>			CPT/HCPCS A9999-DME SUPPLY OR ACCESSORY, NOS		1.000	0

Attachments

#	Transmission Method	File	Control #	Attachment Type
1	FT-File Transfer	Physician Order.PNG (0K)		D2-Physician Order

Back

Confirm

Cancel

Complete the required information and submit the request by clicking **Confirm**.



Viewing Prior Authorization Status

- The authorization request is assigned an authorization number
- Results list the first 20 authorizations with beginning service dates of today or greater
- Results list only authorizations for which the viewing provider was on the request as the requesting provider

View Authorization Status

Search Options Prospective Authorizations

Prospective authorizations identifying you as the Requesting or Rendering Provider are listed below. These results include the first (20) authorizations with a beginning Services Date of today or greater. Click the Authorization Number to view the authorization response details or select the Search Options tab to search for a different authorization.

Prospective Authorizations						
Click on a Column Heading to change the sort order						
Authorization Number	Service Date ▲	Member Name	Member ID	Service Type	Requesting Provider	Rendering Provider

Click to view the authorization

Member name and ID are displayed

Requesting provider is listed



Claims Fee-for-Service

Search Claims

Why did my claim deny? First...search by:

- Claim ID
 - Member information and date of service that matches your claim **EXACTLY**

Search Claims ?


Medical/Dental/Institutional

Either the Paid Date or Service From and To date are required fields when the Claim ID is not entered.

Claim Information

Claim ID



Member Information


Member ID Birth Date 

Last Name First Name

Service Information

Claim Type

Service From  To  Claim Status

Paid Date 

Search **Reset**






Claim Search Results

- To view the claim summary, click the plus sign (+) next to the Claim ID
- To view the claim explanation of benefits (EOBs), click the **Claim ID**

Search Results


To see service line information or to view a remittance advice, click on the '+' next to the claims ID.

Total Records: 558

+/-	<u>Claim ID</u>	<u>Claim Type</u>	<u>Claim Status</u>	<u>Service Date</u> ▼	<u>Member ID</u>	<u>Rendering Provider ID</u>	<u>Medicaid Paid Amount</u>	<u>Paid Date</u>	<u>Member Responsibility</u>
	000000000000	Professional	Finalized Payment				\$101.23		
		Professional	Finalized Payment				\$82.28		
		Professional	Finalized Payment				\$51.99		
		Professional	Finalized Payment				\$76.88		
		Professional	Finalized Payment				\$137.16		

Why Did My Claim Deny?

Always review the Claim Explanation of Benefits (EOB) as they are IHCP specific denials

Claim EOB Information 			
Claim / Service #	Disposition	EOB Code	Description
Claim	Deny	0815	TPL REQUIRED AT DETAIL AND MUST SUM TO EQUAL THE HEADER TPL AMOUNT
Claim	Deny	0815	TPL REQUIRED AT DETAIL AND MUST SUM TO EQUAL THE HEADER TPL AMOUNT

Claim Updates

Claim EOB Information



Claim Adjustment Reason Code Information



Adjudication Errors



No Occurrence Codes exist for this claim

No Surgical Procedures exist for this claim

No Attachments exist for this claim

No Claim Notes exist for this claim

Copy

Print Preview

Click COPY when rebilling a denied claim

Claim Updates

Claim EOB Information



Claim Adjustment Reason Code Information



No Other Insurance Details exist for this claim

No Condition Codes exist for this claim

No Occurrence Codes exist for this claim

No Value Codes exist for this claim

No Surgical Procedures exist for this claim

No Attachments exist for this claim

No Claim Notes exist for this claim

No Adjudication Errors exist for this claim

Edit

Copy

Void

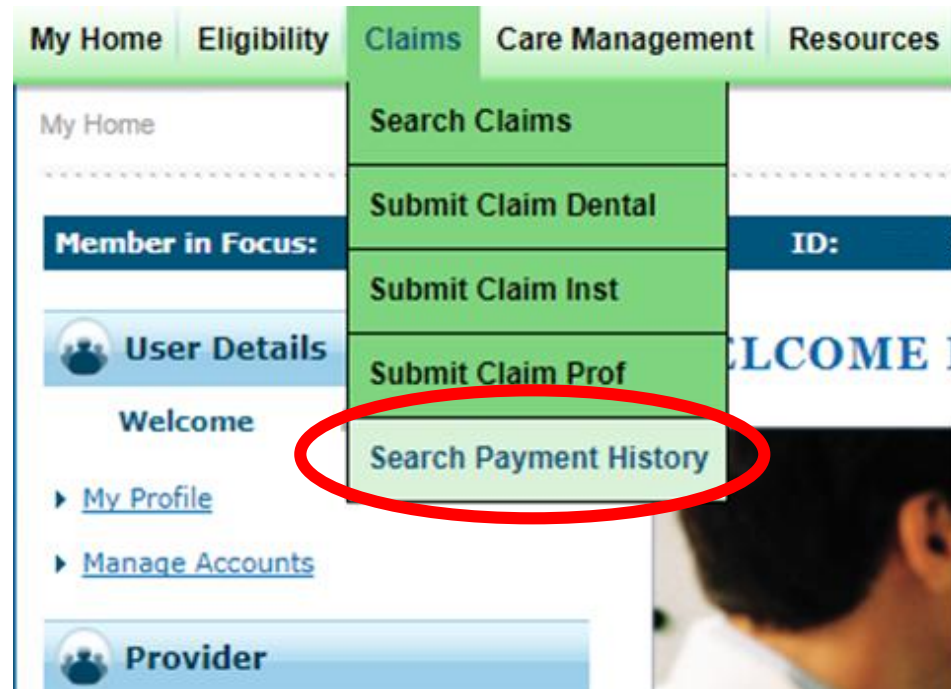
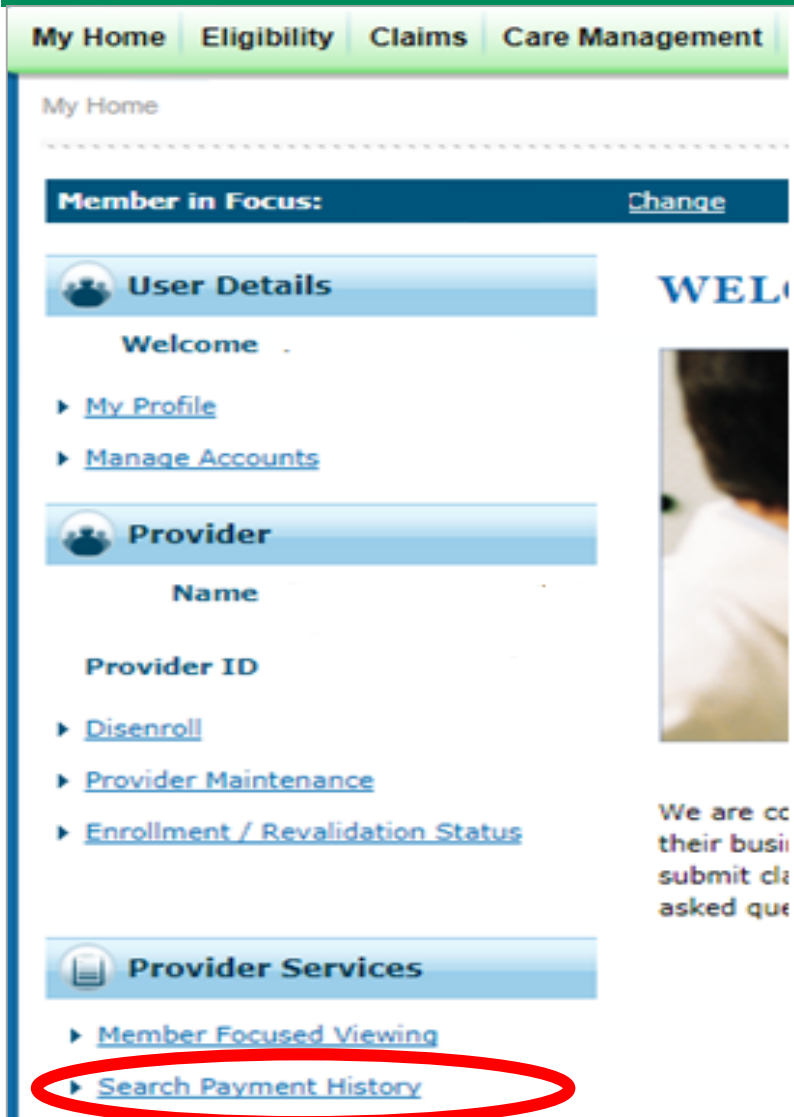
Print Preview



Click EDIT to make claim corrections
Click VOID to have the claim recouped

Search Payment History

Where Do I Find My Remittance Advice on the Portal?



Search Payment History

Search Payment History



Provider Information

Provider ID

ID Type NPI

Name

* Indicates a required field.

Enter a From and To Issue Date that does not span more than 90 days. To further refine the search, select a Payment Method and/or enter a Payment ID.

Payment Method

Payment ID

Issue Date *From

*To

Search

Reset

- Auto-populates last 12 weeks, or search by 12-week span

* Indicates a required field.

Enter a From and To Issue Date that does not span more

Payment Method

Issue Date *From

Check
EFT
None
Other

- You can search ALL payments, or search for paper checks or electronic funds transfer (EFT) only






Search Payment History

Search Results

To see payment details, click on the Payment ID link.

To access a copy of the Remittance Advice, select the RA icon. Access to the RA will require Adobe Acrobat Reader.

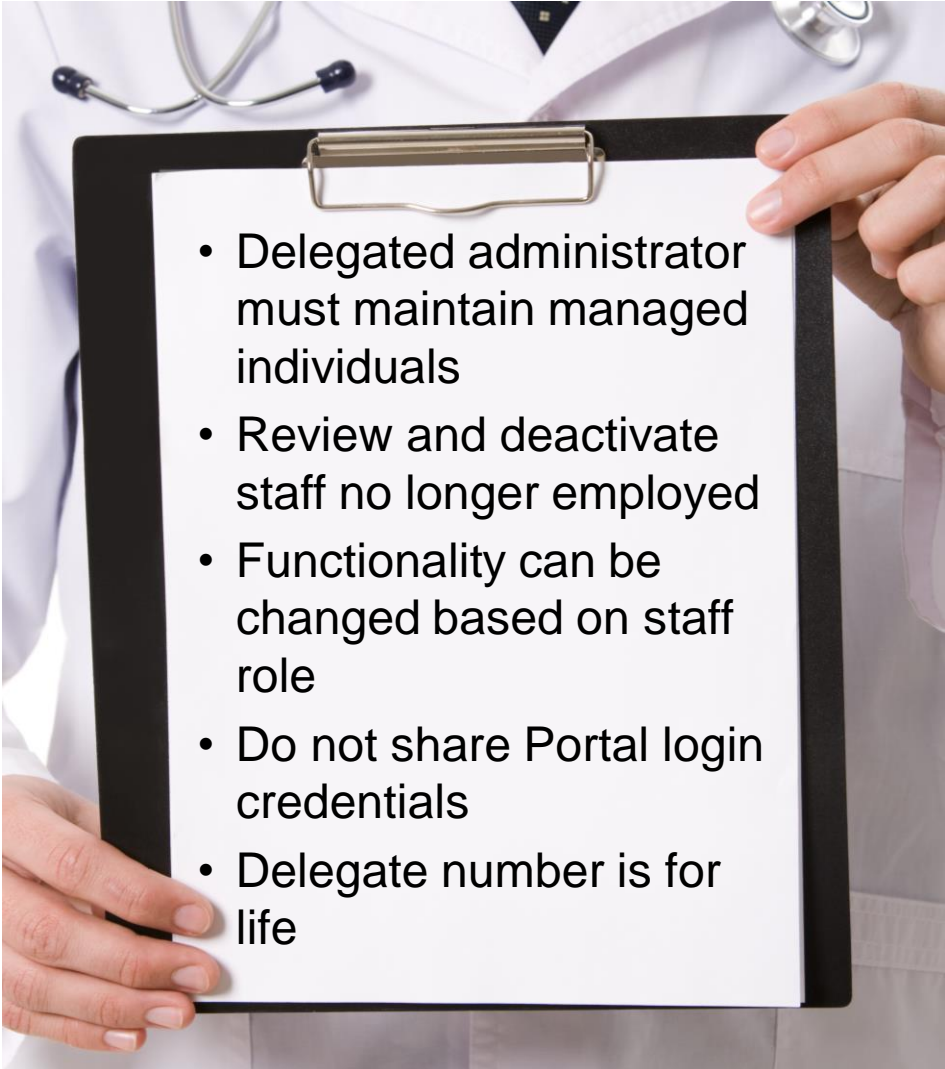
Total Records: 13

<u>Issue Date</u> ▼	<u>Payment Method</u>	<u>Payment ID</u>	<u>Total Paid Amount</u>	<u>RA Copy (PDF)</u>
07/17/2019	Check	000000000	\$0.00	
07/10/2019	Check	000000000	\$0.00	
07/03/2019	Check	000000000	\$0.00	

To view the Remittance Advice for claims associated with the EFT or check, click the icon for the PDF file.

Reminders

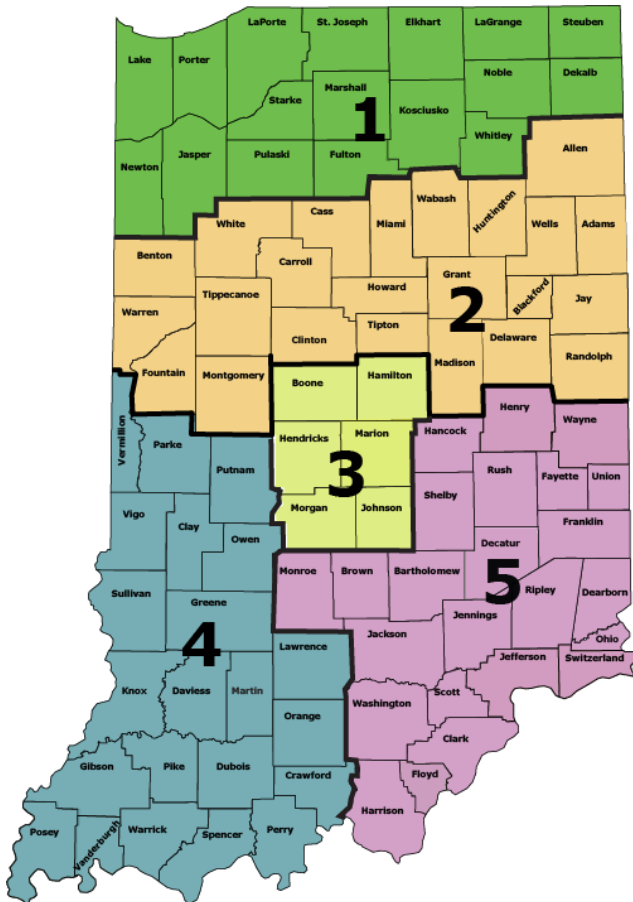
Reminders

- 
- A person wearing a white lab coat and a stethoscope is holding a black clipboard. The clipboard has a white sheet of paper with a list of reminders. The person's hands are visible at the bottom and right sides of the clipboard.
- Delegated administrator must maintain managed individuals
 - Review and deactivate staff no longer employed
 - Functionality can be changed based on staff role
 - Do not share Portal login credentials
 - Delegate number is for life

Helpful Tools

Helpful Tools

Provider Relations Consultants



Region	Field Consultant	Email	Telephone	Counties Served
1	Jean Downs	INXIXRegion1@dxc.com	(317) 488-5071	Dekalb, Elkhart, Fulton, Jasper, Kosciusko, LaGrange, Lake, LaPorte, Marshall, Newton, Noble, Porter, Pulaski, St. Joseph, Starke, Steuben, Whitley
2	Shari Galbreath	INXIXRegion2@dxc.com	(317) 488-5080	Allen, Adams, Benton, Blackford, Cass, Carroll, Clinton, Delaware, Fountain, Grant, Howard, Huntington, Jay, Madison, Miami, Montgomery, Randolph, Tippecanoe, Tipton, Wabash, Warren, Wells, White
3	Crystal Woodson	INXIXRegion3@dxc.com	(317) 488-5324	Boone, Hamilton, Hendricks, Johnson, Marion, Morgan
4	Amber Keegan & Emily Redman (interim)	INXIXRegion4@dxc.com	(317) 488-5153	Clay, Crawford, Daviess, Dubois, Gibson, Greene, Knox, Lawrence, Martin, Orange, Owen, Parke, Perry, Pike, Posey, Putnam, Spencer, Sullivan, Vanderburgh, Vermillion, Vigo, Warrick
5	Virginia Hudson	INXIXRegion5@dxc.com	(317) 488-5186	Bartholomew, Brown, Clark, Dearborn, Decatur, Fayette, Floyd, Franklin, Hancock, Harrison, Henry, Jackson, Jefferson, Jennings, Monroe, Ohio, Ripley, Rush, Scott, Shelby, Switzerland, Union, Washington, Wayne

Helpful Tools

IHCP website at in.gov/medicaid/:

- *IHCP Provider Reference Modules*
- Contact Us – Provider Relations Field Consultants

Customer Assistance available:

- Monday – Friday, 8 a.m. – 6 p.m. Eastern Time
- 1-800-457-4584

Secure Correspondence:

- Via the Provider Healthcare Portal
 - After logging in to the Portal, click the **Secure Correspondence** link to submit a request



Questions?